**ADMISSIONS PACKET**

 *PLEASE READ CAREFULLY*

 Mary Kendall Counseling Services maintains the following business hours:

 Monday – Friday 8:00 AM to 5:00 PM

\* After hours and weekend appointments are available and can be scheduled directly with the client’s therapist or case manager.

**Mary Kendall Counseling Services observes the following holidays:**

* New Year’s Day (January 1st)
* Martin Luther King Jr. Day
* Memorial Day (Last Monday in May)
* Independence Day (July 4th)
* Labor Day (1st Monday in September)
* Thanksgiving Day (4th Thursday in November)
* Christmas Eve and Christmas Day (December 24th and 25th)

**After Hours Emergencies**

If you are experiencing an emergency and believe you cannot keep yourself, a family member, or a friend safe, you should contact any of the following resources:

1. Call 911
2. Contact the local Crisis Line: 1-800-433-7291
3. Suicide Prevention Lifeline Phone: 1-800-273-TALK (8255)
4. Text HELLO to 741741 to text with a crisis counselor
5. Visit your local hospital emergency room
* Owensboro Health Regional Hospital – (270) 417-2000

1201 Pleasant Valley Rd., Owensboro, KY 42303

It should be understood that email and telephone correspondence to Mary Kendall staff will be reviewed as soon as possible but should not be relied upon in an emergency situation. If the situation is not an emergency, please wait until the next business day to contact your case manager or therapist directly.

**Scheduling & Cancelling Appointments**

Appointments can be scheduled by contacting your therapist and case manager directly. We realize that, on occasion, you may not be able to make a scheduled appointment. Please notify us via phone as soon as possible if you will need to cancel or reschedule an appointment (*leaving a voicemail if we do not answer*). Please remember that your appointment time has been reserved for you alone so our policy is to charge a missed appointment fee of $25 if you do not provide at least 24-hour advanced notice.

Clients who frequently cancel, reschedule or miss appointments, especially without giving 24-hour notice, will be discharged from the program at our discretion.

**Treatment Process**

Services through Mary Kendall Counseling begin with an intake and assessment. Your clinician and case manager will talk with you about your current situation, ask you about your history, and make a recommendation for services. You will then develop a “treatment plan” together that outlines how services will go and what outcomes are expected.

Individual sessions usually last 45 minutes to 1 hour. Frequency of sessions may vary depending on the therapists’ recommendations. Your clinician will talk with you about what is recommended for you.

Family therapy is also available.

**Minors and Custody**

Our role is to help people with mental health concerns make lasting life improvements. It is not our role to conduct a custody evaluation, determine whether a parent is “fit” or not, recommend one parent over another, nor focus on reunification of a child and parent. We will not testify in court about custody issues unless we are compelled by a court. If you need help with custody issues, we can refer you to clinicians who specialize in this area.

For youth with divorced parents, we expect parents to communicate with each other about services, decide who will schedule appointments, who will assist with transportation to appointments, etc. The clinician and the youth cannot be messengers between parents.

It is important to note that both parents have access to a child’s records, regardless of custody. The only exception is if parental rights have been revoked.

Since youth benefit from an expectation of some privacy, we try not to share details of what a youth says or does in treatment. We will share progress in treatment, as well as notify parents/guardians of any risks of harm. We include parents/guardians in treatment for the benefit of the youth.

**Minor Consent**

Per Kentucky law, Mary Kendall Counseling Services may provide mental health treatment to a youth age sixteen (16) or older upon the request of the minor without the consent of parent, parents, or guardian. We may provide substance use treatment to any minor under the age of eighteen (18) upon request of the minor without consent of parent, parents, or guardian.

If you are a minor signing these documents, you authorize your clinician to use their best judgement to decide whether to contact your parents or not. It is also important to know that parents have a right to access minor’s records, unless parental rights have been revoked, up until the minor turns 18 years of age.

\*This does not include psychotherapy progress notes, which are considered property of the provider\*

**Client Rights & Responsibilities**

* Participants have the right to be informed of agency service hours and applicable fees for service.
* Clients have the right to be informed when it is not within the capacity of KYUMH to provide the level of care needed. The client, parent and/or legal guardian will be notified of alternative provisions for care, including if necessary, transfer to another facility, service or program.
* Clients have the right to individualized treatment planning which includes:
* Adequate and respectful services regardless of the source(s) of financial support;
* Receipt of services in a manner that is non-coercive and protects the right of self-determination;
* A provision of services within the least restrictive environment possible;
* An individualized treatment care plan;
* A periodic review of the treatment care plan
* The client and their family have a responsibility to provide, to the best of their ability, all necessary information that will assist in treatment and to report any changes of significance.
* Clients have the right to be treated with respect regardless of race, religion, gender, sexual orientation, ethnicity, age, or disability. Clients have the responsibility to treat others with the same level of respect.
* For minors under age 18 year of age, a parent/legal guardian has a responsibility to be involved in the youth’s treatment and must participate in a minimum of one (1) face-to-face case management meeting per month.
* Clients have the right to confidentiality as outlined in the agency’s Notice of Privacy Practices.
* Clients and their families have the right to be informed of the parameters surrounding their care in a language that they can understand. If needed, translation services will be provided as follows:
* Accommodations will be made for documents needing translation.
* Should the client speak English as a second language and they are not competent in the basic use of English, the agency will obtain an interpreter who is fluent in that non-English language.
* Clients have the right to the agency’s grievance procedure if they feel their rights have been violated.
* Clients have the right to refuse treatment offered.
* Clients have the right to give informed written consent for treatment.

**Notice of Privacy Practices (HIPAA)**

*This notice describes how your protected health information (PHI) may be used and disclosed and how you can access this information. Please review it carefully. Protecting our clients’ privacy is important to this practice. The Health Insurance Portability and Accountability Act (HIPAA) requires us to maintain your privacy, to provide you with a copy of this notice, and to follow the terms of this notice. The law permits us to use or disclose your health information to those involved in your treatment; for example, a review of your file by a specialist who may be involved in your care.*

* We may use or disclose your health information for payment of your services. For example, we may send a report of your progress to your insurance company. You have the right to restrict the disclosure of PHI to your insurance company if you pay for services in full.
* We may use or disclose your health information for our normal health care operations. For example, one of our staff will enter your information into our computer. Use and disclosure of you PHI for marketing purposes and the sale of PHI is not allowed without your written authorization.
* We may share your medical information with your business associates, such as a billing service. WE have a written contract with each business associate that requires them to protect your privacy.
* Uses and disclosures of the separate Psychotherapy Notes require your written authorization.
* We may use your information to contact you and we will use whatever address or telephone number you prefer. For example, we may need to call and remind you about your appointments. In an emergency, we may disclose your health information to a family member or another person responsible for your care. We may also send you automatic appointment reminders. You may opt out of this service.
* We may release some or all of your health information when required by law. Sale of your PHI to third parties is prohibited.
* Except as described above, this practice will not use or disclose your health information without your prior written authorization.
* You have the right to know of any uses or disclosures we make with your health information beyond the above normal uses.
* You have the right to transfer copies of your health information to another practice.
* You have the right to see or receive a copy of any of your health information and can request, in writing, an amendment or change to your health information. We may or may not make the changes you request, but will be happy to include your statement in your file. If we agree to an amendment or change, we will not remove or alter earlier documents, but will add new information.
* We utilize electronic systems to store some of your PHI. Should a breach in security occur, we are required to notify you within 60 days of the occurrence of said breach.
* You have the right to receive a copy of this notice. If we change any of the details of this notice, we will notify you of the changes in writing.

You may revoke an authorization, at any time, in writing, except to the extent that your provider or we have taken action in reliance on the use or disclosure indicated in the authorization. To revoke an authorization, you must write to Mary Kendall Counseling Services at the following address:

KY United Methodist Homes

Attn: Mary Kendall Counseling Services

201 Phillips Court

Owensboro, KY 42303

**Grievance Policy**

*PLEASE READ CAREFULLY*

We have an obligation to provide a method to address any grievance for which the client may feel that we have done to any of his/her rights. “Grievance” is defined as: “any circumstance for which there is just cause for protest”.

**The grievance procedure for Mary Kendall Counseling Services shall be as follows:**

All grievances shall be made in writing to the Mary Kendall Counseling Services Clinical Supervisor/Administrator. If the complaint is made by telephone, personnel will connect the client or family member with the appropriate Clinical Supervisor/Administrator. The Clinical Supervisor/Administrator will document the complaint either by pone or at a scheduled meeting to assure an understanding of the nature of the grievance and to have the client or family member sign the grievance form. If the grievance involves the agency Clinical Supervisor/Administrator the staff will contact the Administrator’s supervisor to complete the grievance report.

The Clinical Supervisor/Administrator is required to investigate, review and make a written determination of his/her findings including action to be taken to address the complaint. A Copy of the written report will be given to the client upon its completion.

The Clinical Supervisor/Administrator is required to refer the grievance and his/her report to the PQI office.

Should the grievance be of such a nature that it is reasonable to consider that a legal question has been raised, the Administration shall refer the grievance and his/her report to the attorney of record for the agency.

Of the advice of said attorney, the administrator shall make the client grievance to the appropriate law enforcement authority. In all cases, every attempt will be made by all parties to resolve grievances informally within thirty (30) working days.

**The client has a right at any step of the grievance review process to take his/her grievance directly to:**

Health and Human Services: 1-800-368-1019

U.S. Department of Health and Human Services

200 Independence Avenue, SW

Room 509F, HHH Building

Washington, D.C. 20201

You may file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through he Office of Civil Rights Complaint Porta, available at:

<https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>

Mary Kendall Counseling Services is required to comply with and adhere to the Civil Rights Act of 1964 and all subsequent amendments: including religious, age, sex, and political affiliation as all relate to any and all civil rights which are granted/implied by statue law.

Each new client will be given a copy of the grievance procedure and have this procedure explained at intake.

**FINANCIAL POLICIES & AGREEMENT**

*PLEASE READ CAREFULLY*

**Insurance Billing**

If you plan to use insurance to pay for services, claims will be sent to the insurance company based on information used at the time of service. Insurance co-payments, co-insurances and deductible payments are due at the time of services. **Co-pays are not negotiable**. Failure to pay your part may jeopardize your benefits. In the event of non-payment from your carrier, you are responsible for payment to Mary Kendall Counseling Services for services rendered and you will be responsible for handling any disputes with your insurance carrier. Please note that dependent on your financial agreement with us, you will now receive a monthly statement reflecting the services you have received each month. These statements will be mailed to your address on file. If you have insurance coverage with accompany that we are in-network with, you will have the option to have your services billed to your insurance and your monthly statement twill reflect any applicable co-pays.

Please note: Treatment information including diagnosis, type of treatment, costs of service, dates of service, and providers, may be shared with your insurance carrier for reimbursement purposes. Please be aware that any information communicated to your carrier may affect your benefits. If you decide to file through insurance, we reserve the right to share this information with your carrier upon their request.

**Self-Pay/Sliding-Fee Scale**

Please note that Mary Kendall Counseling Services has implemented a Sliding-Fee Scale. Fees for services are based on household income as well as other factors. Mary Kendall Counseling Services will be provided at a discounted rate, to persons able to declare financial hardship using the **Sliding Fee Scale Application** (copies of this application will be provided upon request). Please note that dependent on your financial agreement with us, you will now receive a monthly statement reflecting the services you have received each monthly. These statements will be mailed to your address on file. If you do not have insurance or elect to self-pay for your services, your monthly statement will reflect any fees that may be due based on your financial agreement with us.

**Outstanding Balance**

You are responsible for paying any outstanding balances due on your account. Once we receive an Explanation of Benefits from your insurance carrier, your balance may be adjusted based on your carrier’s allowed amount. If an account accrues two or more unpaid sessions, ongoing services may be immediately postponed until full remittance is received. Please be advised that if Mary Kendall Counseling Services does not receive payment in full for services rendered, your treatment may be discontinued.

If your account has not been paid for more than 60-days and arrangements for payment have not been agreed upon, our office has the option of using legal means to secure payment. This may involve hiring a collection agency or going through small claims court. \*If such legal action is necessary, the costs will be included in the claim and responsibility of the client. \*

**Late Cancellations/No Shows**

For a missed or late cancelled appointment, you will be charged a $25 missed appointment fee. Missed appointment fees are the responsibility of the client or “financial guarantor” (parent/guardian). Appointments must be cancelled no less than 24-hours before the scheduled appointment time. **Repeated late cancellations and/or no-shows may result in discharge from services at our discretion.**

**Changes to the Policy**

Mary Kendall Counseling Services reserves the right to change this agreement as necessary and in accordance with all applicable laws. Current copies of this agreement can be requested at any time.

**Consent for Treatment**

*PLEASE READ CAREFULLY*

By signing this form, you agree to receive mental/behavioral health services, including Therapy and Targeted Case Management, by Mary Kendall Counseling Services, a community-based program of the Methodist Home of Kentucky. This form explains information about Mary Kendall Counseling Services policy, state and federal laws, and your rights in regard to counseling.

 *I understand that in order to better serve me and/or my child, the collaboration of numerous agencies and service providers may*

 *be required to facilitate the above treatment. I understand that this collaboration requires the exchange of information about me*

 *and/or my child and our family to assist service providers in making necessary assessments, service plans and to provide*

 *comprehensive treatment. KYUMH collaborates with Commonwealth Health Management as an authorized billing management*

 *company. I have been advised of my rights regarding privacy practices and have provided my consent on the appropriate Releases*

 *of Information.*

**Telehealth**

Telehealth offered by Mary Kendall Counseling Services is voluntary, and it may be ended by you at any time. The laws that protect the confidentiality of your personal information, such as HIPAA, also apply to telehealth at Mary Kendall Counseling Services. The platform used by Mary Kendall Counseling Services to deliver IHPAA-compliant telehealth service delivery is Zoom. As a general practice, Mary Kendall Counseling Services DOES NOT record Telehealth sessions without prior permission.

There are risks and consequences of Telehealth, including but not limited to, the possibility, despite reasonable efforts on the part of Mary Kendall Counseling Services that: The transmission of your information could be disrupted or distorted by technical failures; the transmission of your information could be interrupted by unauthorized persons; and/or the electronic storage of your medical information could be accessed by unauthorized persons.

 *I understand that in case of technology failure, I should contact my Mary Kendall Counseling Services clinician or other staff*

 *member via phone to coordinate alternative arrangements for treatment.*

At times, Telehealth may not be as effective as face-to-face services. If a Mary Kendall Counseling Services provider believes you would be better served by another service delivery modality (e.g., face-to-face services), they will refer you to a professional who can provide such services in your area or recommend in-person office visits. Telehealth appointments are considered outpatient services and not intended as a substitute for emergency or crisis services. Crisis or mental health emergencies should be directed to dialing 911.

**I understand I have the following rights with respect to Telehealth:**

1. I have the right to withdraw my consent at any time
2. I understand there are risks and consequences associated with telehealth including, but not limited to the possibility, despite reasonable efforts on the part of my therapist that the transmission of my medical information could be disrupted or distorted by technical failures.
3. I understand I have a right to access my mental health information and copies of medical records in accordance with federal and state laws.

**Transportation**

Authorized staff of the KY United Methodist Home have my permission to transport me/my child (for parents/guardians) as part of treatment services offered within Mary Kendall Counseling Services. I authorize program staff to transport to/from school, as well as other destinations as required for program participation. I understand these staff will take every reasonable precaution to maintain my/my child’s safety. I will not hold the KY United Methodist Home or its staff liable in the event of an accident and assume full responsibility for any medical treatment required in the event of an accident.

**Confidentiality and Emergency Situations**

Confidential information discussed in sessions is not discussed with anyone without your written permission, except for:

1. Diagnosis and dates of service shared with your insurance company to process your claims;
2. Information you tell Mary Kendall Counseling Services about physical, sexual, or elder abuse; then, by Kentucky State Law, your clinician will have to report this to the Kentucky Department of Children and Family Services.
3. When you sign a release of information to have specific information shared.
4. If you tell Mary Kendall Counseling Services you are in danger or harming yourself or others.
5. Information shared with therapist’s clinical supervisor if applicable.
6. When required by law.

**Acknowledgement of Receipt of:**

Informed Consent

Client Rights & Responsibilities

Privacy Policies

Financial Policies

Grievance Procedures

**Copy for Client and MKCS**

Client Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Client Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Guardian Name (if applicable): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Parent Guardian Other

 Initial

**Informed Consent**

I have read and understand the risks & benefits related to treatment and evaluation through Mary Kendall

Counseling Services. I consent to receive mental health and substance use services by Mary Kendall Counseling

Services, including Targeted Case Management. Any questions I have regarding these services have been answered.

I have a copy of these policies. \_\_\_\_\_\_\_\_\_

**Client Rights & Responsibilities and Grievances**

I have read and understand my rights and responsibilities and the grievance procedures for services through Mary Kendall Counseling Services. This includes fees, no-show/cancellation policies, and my rights. I have a copy of these rights & responsibilities. Any questions I have regarding these topics have been answered. I have a copy of these policies. \_\_\_\_\_\_\_\_\_\_

**Notice of Privacy Practices**

I have read and understand Mary Kendall Counseling Services’ privacy practices. This includes HIPAA privacy policies and exceptions to confidentiality. Any questions I have regarding these practices have been answered. I have a copy of these policies. \_\_\_\_\_\_\_\_\_\_

**Financial**

I have read and understand Mary Kendall Counseling Services’ financial policies & agreement. I hm the “financial guarantor,” meaning I will be responsible for payment of co-pays, co-insurance, deductibles, and fees for services not covered by my insurance plan. Any questions I have regarding these practices have been answered. I have a copy of these policies. \_\_\_\_\_\_\_\_\_\_

Participant’s Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Application for Services**

To qualify for Mary Kendall Counseling Services, a participate must:

* Be a resident of one of the eligible counties served by the program
* Have a mental health and/or substance use disorder
* Have submitted a completed referral
* Agree to participate in an initial drug screening if needed

 **NEW**: I have never participated in Mary Kendall Counseling Services program

 **RETURNING:** I have previously participated in the Mary Kendall Counseling Services program

**Participant Information**

|  |  |  |
| --- | --- | --- |
| Social Security # | Date of Birth | Application Date  |
| First Name | Middle Name | Last Name |
| Home Address  |
| Apartment # | City | State**KY** | Zip Code |
| County | Primary Telephone # |
| Email Address | Alternate Telephone # |

 **PRIMARY PARENT/CAREGIVER INFORMATION (If Applicable) OR Emergency Contact**

|  |  |
| --- | --- |
| First Name | Last Name |
| Relationship to Client  | Primary Telephone # |
| Email Address | Alternate Telephone # |

How many people reside in the household, including the participant? \_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Employment**:

If under age 18, is the participant’s primary parent/caregiver currently employed? Yes No

 If yes, what is their occupation? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is the participant currently employed? Yes No

 If yes, name and location of employment: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please check any benefits currently receiving:**

 Kentucky Medicaid Program (KMP) Kentucky Transitional Assistance Program (K-TAP)

 Veteran’s Benefits Kentucky Children’s Health Insurance Program (KCHIP)

 Supplemental Nutrition Assistance Program (SNAP) Kentucky Unemployment Insurance

 Social Security (SSDI/SSI) Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Participant’s Living Arrangement**:

 Living with parent Living with Relative Emancipated Living with guardian

 Other living arrangement: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Participant’s Adverse Legal History**:

 None Includes:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Religious, Ethnic and Cultural Background**:

 American Indian or Alaskan Native Asian Black/African American Caucasian/White

 Native Hawaiian/Pacific Islander Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Ethnicity: Hispanic or Latino Non-Hispanic / Non-Latino

Gender participant identifies with: Female Male Gender nonconformity

Religious / Spiritual preferences: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Sexual Orientation: Heterosexual Lesbian Bisexual Transgender Homosexual

 Questioning

**Educational Functioning:**

Is participant currently enrolled in school? Yes No

Name of School: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Current Grade: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Identified special needs or disability: None Yes: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**HEALTH STATUS QUESTIONNAIRE**

*This questionnaire is designed to provide a general overview of the participant’s health*

Primary Care Physician Information

|  |  |
| --- | --- |
| First Name | Last Name |
| Office Address |
|  |
| Suite #  | City  | State**KY** | Zip Code |
| Office Telephone # |

Please list any known medical conditions, including allergies:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does participant need assistance with accessing health care services? Yes

 At this time, I decline help with accessing health care services

Participant’s height: \_\_\_\_ ft. \_\_\_in. Participant’s weight: \_\_\_\_\_\_lbs.

Are you concerned about your risk for sexually transmitted diseases or feel that you may be at risk for being HIV positive? Yes No

List any medications, dosage, and reason for medications participant is currently taking:

|  |  |  |
| --- | --- | --- |
| **Medication** | **Dosage** | **Reason** |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

Any known drug allergies? No Yes: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you drink water each day? Yes No Do you get regular physical activity? Yes No

Are you current with your vaccinations? Yes No

How would you describe your sleep? *Well Trouble falling asleep Trouble staying asleep Insomnia*

Do you have nightmares? No Sometimes Often

**Insurance Information**

**Primary Insurance Information** (family member whose insurance you are covered by)

Policy Holder’s Full Name (Including Middle): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Policy Holder’s Birthdate: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Policy Holder’s Social Security Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insurance Plan Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Subscriber Number or Member ID Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Group Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Secondary Insurance Information** (If applicable)

Policy Holder’s Full Name (Including Middle): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Policy Holder’s Birthdate: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Policy Holder’s Social Security Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insurance Plan Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Subscriber Number or Member ID Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Group Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_Please initial if you do not want to use your insurance benefits; you will be charged the self-pay rate for services. \*See Sliding Fee Scale Application and Guidelines\*

*I certify the information provided in this application is true and accurate to the best of my knowledge.*

Participant’s signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mary Kendall Counseling Services Staff Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_